(3)

Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

NEVA MURRAY, INDIVIDUALLY AND AS GUARDIAN OF HUGH MURRAY, WARD,

Petitioners

v.

CROSSMARK SALES, INC.;
CONNECTICUT GENERAL LIFE INSURANCE CO.; AND
GROUP & PENSION ADMINISTRATORS, INC.

Respondents

On Petition for a Writ of Certiorari To The United States Court of Appeals for the Fifth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

(1) In the 17 years since this Court held, in *Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 954 (1989), that the appropriate standard of review of benefit determinations of an ERISA administrator with discretion was abuse of discretion, this standard of review has proven untenable. Considering that ERISA claimants' state law claims for unfair claims practices are preempted, that statutory damages for ERISA administrators' procedural failures are limited and set to a 1970's standard of living, and that ERISA administrators now administer benefits with virtually no judicial review:

Should this Court reconsider the part of *Firestone v. Bruch* decision allowing for abuse of discretion review in ERISA cases?

(2) This Court has required the development of a federal common law of rights and obligations under ERISA-regulated plans. The Courts of Appeals are divided over the following question of federal common law under ERISA:

Whether ERISA plans must be interpreted and ERISA administrator decisions reviewed under the doctrine of "Reasonable Expectations"?

CERTIFICATE OF PARTIES TO THE PROCEEDIN(AND CORPORATE DISCLOSURE STATEMENT

The following listed persons have an interest in th outcome of this case. These representations are made in ord(that the justices of this Court may evaluate possibl disqualification or recusal. The parties to the proceedings belo· are Petitioners Neva Murray and Hugh Murray, ward, an Respondents Crossmark Sales, Inc., Connecticut General Lif Insurance Co., and Group & Pension Administrators, Inc.

Pursuant to Rule 29.6, Petitioners state that they ar natural persons and not corporations.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Neva Murray, individually and as guardian of Hugh Murray, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is unreported. The opinion of the United States District Court for the Western District of Texas is unreported. These opinions are included in the Appendix.

JURISDICTION

The United States Court of Appeals for the Fifth Circuit rendered judgment on January 23, 2006. This Petition for Writ of Certiorari is within 90 days of that date and is timely. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1001(a) of The Employee Retirement Income and Security Act) ("ERISA") states that

> "owing to the lack of employee information and adequate safeguards concerning [benefit plan] operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans."

29 U.S.C. § 1001b(c) of ERISA states that "It is hereby declared to be the policy of this title * * * (3) to increase the likelihood that participants and beneficiaries . . . will receive their full benefits."

29 U.S.C. § 1132(a) of ERISA states that "[a] civil action may be brought * * * (1) by a participant or beneficiary * * * (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

Relevant portions of ERISA, 29 U.S.C. § 1001, *et seq.*, together with relevant portions of the implementing regulations, are included in the Appendix.

STATEMENT OF THE CASE

A. Facts Relevant to Issues Presented for Review

Petitioner Neva Murray has received comprehensive major medical coverage through her employer, Respondent Crossmark Sales ("Crossmark") since 1996. This self-funded benefits plan was administered by Respondent Group & Pension Administrators ("GPA") through February, 2001. From March 1, 2001 to present, Respondent Connecticut General Life Insurance Co. ("CIGNA") has administered the plan.

Petitioner, when she first enrolled, received neither a Summary Plan Description ("SPD") nor a copy of the plan

itself,[1] but was provided an "enrollment guide," generally outlining plan benefits and requirements, but not exclusions. When the GPA plan benefits were amended in January, 1997 and January, 1999, Mrs. Murray again received brief summaries, but not full SPDs or information regarding exclusions. When CIGNA assumed administration, Mrs. Murray again received an "enrollment guide" regarding benefits under the CIGNA plan, but neither an SPD nor copy of the plan.

The evidence indicates that once CIGNA assumed administrative duties on March 1, 2001, it administered the Crossmark plan without benefit of any governing documents – whether SPD or plan – until July , 2001.

When Mrs. Murray requested copies of the CIGNA and GPA SPD's on March 7, 2001, she was referred by Crossmark's Human Resources department to a company website, but neither the SPD's nor the plans were posted there. Once the documents were posted (on August 2, 2001), employees could not print out copies, but could only view them online while at work. Non-employee beneficiaries had no access to the plan or SPD. The documents that were posted were buried in hundreds of layers of computer folders. These folders were not themselves accurate; should an employee have clicked on "Medical Plan," the employee would be informed "there are no items to show" in that file.

Mrs. Murray enrolled her husband, Hugh Murray, as a

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[1] The Respondents have not produced separate SPD's and plans. They have claimed that, for all relevant plans, the plan is the SPD and the SPD is the plan.

dependent on her comprehensive major medical plan in Marcl 2000. On February 12, 2001, Hugh Murray, in the course c providing pest control, fell from the attic space in a singl family residence onto the concrete floor of the garage below He suffered severe closed head trauma, open head trauma an a broken left arm. He was comatose for five weeks, require further hospitalization for several weeks beyond the coma, an was eventually moved to a nursing facility. Hugh Murray ha had to undergo at least two surgical procedures to evacuate subdural hematoma. He was intubated, comatose, an ventilator dependent while in the hospital. He has require physical and cognitive rehabilitation and custodial care. Hi cognitive functioning remains drastically impaired. He ha been rendered blind. He can no longer speak. He require assistance with daily living functions and is not able to mak decisions or handle his financial affairs. His medical bills t date exceed $500,000.

Administrative Reasons for Denial

Mrs. Murray submitted claims to GPA for expenses incurred for Mr. Murray's treatment from February 12, 2001 until February 28, 2001. These claims were denied. Claims from March 1, 2001 were submitted to CIGNA. Some of the early claims were paid (approximately $90,000) but all subsequent claims were denied.

The GPA plan is over 70 pages long. The table of contents does not highlight or even list exclusions. Under this Plan (until February 28, 2001), Exclusion Three excludes:

> "Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers Compensation or Occupational Disease Law, or any such similar law."

Throughout the administrative period, and continuing well into the commencement of the lawsuit, Mrs. Murray was informed by Crossmark and GPA that benefits were being denied due to the "Workers Compensation" exclusion in the plan. [2] In communications with both Mrs. Murray and internally, the administrators claimed that the relied upon exclusion was a workers' compensation exclusion, and not a general work-related exclusion.

CIGNA, months after learning of Mr. Murray's extensive claims, drafted its plan, separated out the worker's compensation and work-related exclusions into two separate exclusions, and placed the work-related exclusion as the first-listed one. The CIGNA SPD/plan (from July, 2001) is also over 70 pages long. The table of contents does not have any listing for exclusions. Of 16 entries in the table of contents, all are in the same type and font and all are capitalized. Entry nine (9) of sixteen is "General Limitations" and refers readers to page 53. Unfortunately for a plan participant who wants to learn of the exclusions, page 53 covers vision benefits.

Despite having created a separate work-related exclusion, CIGNA informed Mrs. Murray that it was denying her claims under a worker's compensation exclusion. [3] Like GPA, CIGNA's internal communications indicate that it was denying claims on the basis of the worker's compensation exclusion and not the more general work-related exclusion.

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[2]The references to the "plan" was to a plan that employees did not have physical copies of and that was not yet available on the website.

[3] Again, the reference to the plan was to a plan that employees had no access to and which did not actually exist until several months after the exclusions were claimed.

In response to inquiries regarding subrogation fro Crossmark, GPA and CIGNA, Mrs. Murray provided proof tha her husband was not covered under Texas workers compensation law. Neither was he required to be covered.

From Mrs. Murray's enrollment of Hugh Murray unde the Crossmark plan(s) in March, 2000 through the date of th Final Judgment in the District Court, Mrs. Murray pai premiums, and Crossmark accepted such payment, fo comprehensive major medical coverage for Mr. Murray unde Crossmark's plan. Nonetheless, Respondents indicated, i internal communications, that no administrator was to pay an benefits for Hugh Murray and instructed adjusters to deny al claims, in an apparent decision that all future health care need by Mr. Murray related back to his accident. Claims for Mr. Murray's gastrointestinal and cardiac problems were thus denied.

B. Basis for Jurisdiction and Proceedings Below

This is a case for wrongful denial of benefits under a self-funded employee welfare plan. Federal jurisdiction exists under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

Despite Respondents' filing of multiple answers and amended answers, all of which stated numerous affirmative defenses, no Respondent claimed a plan exclusion as an affirmative defense. Moreover, no Respondent specified the reason for the denial of benefits, other than as "under the terms of the plan." In District Court, Plaintiff litigated the theory that benefit denial pursuant to the inapplicable Worker's Compensation exclusion was arbitrary and capricious.

Well into litigation, during certain questions at Mrs. Murray's deposition, Respondents first hinted that they were claiming a more general work-related exclusion. Not until the summary judgment pleadings did the Respondents finally settle on the theory that they had denied the claims under a work-related exclusion. The case was decided on cross-motions for summary judgment.

The parties settled Petitioners' claims under ERISA for statutory damages for failure to provide a summary plan description to Mrs. Murray. The District Court, on July 22, 2004, found that Respondent's had not waived the affirmative defense of the particular exclusion by not pleading it, reasoning that Petitioners were not surprised or prejudiced. The District Court denied Petitioners' motion for partial summary judgment on liability, and granted Respondents summary judgment that the denial of benefits was not an abuse of discretion. Final judgment in the case, based mostly on the July 22, 2004 order, was entered October 4, 2004, ordering Plaintiff take nothing (dismissed claim for settled statutory damages notwithstanding).

On timely appeal, the Fifth Circuit affirmed the judgment, per curiam, on January 23, 2006, holding that Respondents' pleading of claim denial "in accordance with the terms and conditions of the plan" was sufficient to satisfy both ERISA and FRCP Rule 8.

REASONS FOR GRANTING THE PETITION

A. Summary of the Argument

As Justice Ginsburg has noted, it is time to recogniz "the rising judicial chorus urging that Congress and [this] Cou revisit what is an unjust and increasingly tangled ERIS/ regime." *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 222, 12 S.Ct. 2488, 2503 (2004) (Ginsburg, J., *concurring*) (quotin *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3rd Ci 2003) (Becker, J., concurring)). Justice Ginsburg continue that, "[b]ecause the Court has coupled an encompassin interpretation of ERISA's preemptive force with a crampe construction of the 'equitable relief' allowable under § 502(a)(3), a 'regulatory vacuum' exists: '[V]irtually all stat law remedies are preempted but very few federal substitutes ar provided.'" *Aetna v. Davila* at 200 (quoting *DiFelice v. Aetna* at 456).

The consequences of the "unjust and tangled" ERISA regime are legion. In addition to the lack of equitable relief available and the preemption of state fair claims, insurance, or trade practice law, ERISA claimants may not find refuge in state constitutional provisions. *See Wood v. Prudential Ins. Co. of America*, 207 F.3d 674 (3rd Cir. 2000). Since ERISA precludes statutory penalties, ERISA administrators have an incentive to deny all claims and force claimants to enter court. Once an ERISA claimant goes to federal court to obtain wrongfully denied ERISA benefits, the court itself is constrained in reviewing that benefit determination. In all but the rare case, lower federal courts, in following this Court's decision in *Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 954 (1989), must defer to the administrators' decision. This deference is given, no matter the

adminitrator's decision is barely reasonable. *See Vega v. Nat'l Life Ins. Services*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*). Moreover, this deference is given the administrator even if the administrator itself has grossly flouted ERISA's procedural safeguards for employee/beneficiaries. *See Kreutzer v. A.O. Smith Corp.*, 951 F.2d 739, 744 (7th Cir. 1991) (no substantive rights due to administrator's procedural violations).

When Administrators, like Respondents, have failed to comply with the most basic procedural safeguard afforded plan participants under ERISA – providing a copy of the plan and/or SPD governing claims to participants and beneficiaries (*See* 29 U.S.C. §§ 1022, 1024(b); 29 C.F.R. §§ 2520.104b-1, 2520.104b-3, 2520.107-1(b)(3); *See also* 29 C.F.R. §§ 2560.503-1(b)(5); 2560.503-1(g)) – the Court must ensure that those Administrators may not then use this to their tactical advantage. It is inapropriate for courts, via discretionary review, to enforce an Administrator's strict interpretation of a plan that did not exist, was applied post-hoc, or was never provided to participants. Congress never, in its stated purposes for ERISA, intended to create a category of judicial rubber stamping, let alone judicial complicity in enforcing plan terms not meeting ERISA standards.

The adoption of *de novo* judicial review addresses this problem. The doctrine of Reasonable Expectations provides an additional or alternative safeguard.

B. The Abuse of Discretion standard has proven untenable

ERISA requires that employee welfare plans be governed by a written instrument that is "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29

U.S.C. § 1022(a)(1). For the period from March 1, 2001 to July 2001, no plan documents existed to guide CIGNA' administration of medical claims in this case. This Court ha never explicitly decided the important question of whether backdated or post-hoc instrument may exclude claims fo benefits under an ERISA welfare plan, as Respondents hav done here. Thus, this Court has also never decided whether th abuse of discretion review is appropriate under thes circumstances.

The District Court in this case explicitly held that a failure to provide an SPD does not give rise to substantive rights and the Fifth Circuit affirmed that decision for essentially the reasons stated below. (App.) Other Circuits indicate a reluctance to allow such "informal" mechanisms as unwritten or retrospective amendments to govern claims. *See, e.g., Frommert v. Conkright*, 433 F.3d 254, (2nd Cir. 2006) (an ERISA plan "amendment" occurs not when administrator changes plan, but "when employees are properly *informed* of a change".(emphasis in original)); *Burke v. Kodak Retirement Income Plan*, 336 F.3d 103, 110 (2nd Cir. 2003) (directing entry of judgment for beneficiary prejudiced by deficient SPD); *Confer v. Custom Engineering Co.*, 952 F.2d 41, 43 (3rd Cir. 1991) (informal amendments may not govern benefit determinations and amendments may "operate only prospectively"); *cf. Garst v. Wal-Mart Stores, Inc.*, 30 Fed. Appx. 585, 590 (6th Cir. 2002) (unpublished); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1149 (7th Cir. 1998) (no sustantive remedy).

The issue of the non-existent SPD may be equally well stated as a procedural one. That is, Petitioners are not only claiming a right to recover simply because there was no SPD, but because Respondents may not themselves rely on exclusions that are nowhere mentioned. *Accord Horn v.*

Cendant Operations, Inc., 69 Fed. Appx. 421, 428 (10th Cir. 2003) ("Employees cannot be bound to policy terms for which they received no notice") (unrepoted); *See also Heinglein v. Informal Plan for Plant Shutdown Benefits*, 974 F.2d 391, 400 (3rd Cir. 1992) (in the absense of formal plan documents, courts should consider other documents); *Clark v. Metropolitan Life Ins. Co.*, 67 F.3d 299, WL 592102 at *1 (6th Cir. 1995) (unpublished) ("A plan administrator attempting to establish an exclusion from coverage has the burden to establish by a preponderance of the evidence that a covered employee's illness or medical condition is excludable."); *Donovan v. Dillignham*, 688 F.2d 1367, 1372 (11th Cir. 1982) (although ERISA requires a written instrument, such instrument is not a prerequisite to coverage).

Even when courts have not found that the failure to comply with ERISA SPD regulations gives rise to a substantive right, those same courts have noted that such failure by an administrator may give rise to certain procedural rights. *See, e.g., Burke* at 110 (failed notice and SPD's may allow a *de novo* standard rather than a deferential one). The adoption of a *de novo* standard of judicial review should be the rule in these cases. *Accord Firestone* at 956-957 (review is to be *de novo* unless **the plan** confers discretion). In the absence of a procedurally correct plan conferring discretion, the *de novo* standard is consistent with this Court's reasoning in *Firestone v. Bruch*.

In this case, the post-hoc application of plan documents and exclusions therein to Petitioners' claims is the very definition of arbitrary and capricious. Yet, the courts below did not consider this in their arbitrary and capricious/abuse of discretion analysis. *Cf. Jebian v. Hewlett-Packard Co.*

Employee Benefits Organization Inc. Protection Plan, 349 F.3 1098, 1105 (9th Cir. 2003).

ERISA's purpose is to promote "the interests c employees and their beneficiaries in employee benefit plans through protection of benefits. *Firestone Tire & Rubber v Bruch*, 489 U.S, 101, 113, 109 S.Ct. 948 (1989). To ensur these ends, regulations require that plans provide notice i writing of "the specific reasons for such denial, written in manner calculated to be understood by the participant" whe denying benefits. 29 U.S.C. § 1131.

The Fifth Circuit, below, determined that this "specific reasons" for denial requirement was satisfied by Respondents by their general reference to "plan terms." This directly conflicts with the statutory scheme, and with other circuits. *See VanderKlok v. Provident Life and Accident Ins. Co.*, 956 F.2d 610 (6th Cir. 1992) (failure to reference specific plan provision is inadequate notice); *Clark v. Metropolitan Life Ins. Co.* at *3-4; *Brumm v. Bert Bell NFL Retirement Plan* , 995 F.2d 1433, 1436 (8th Cir. 1993) (denial because "did not meet plan requirements" is "inadequate"). *See also* 29 U.S.C. §1133; 29 C.F.R. § 2560.503-1(g) (ERISA notice particulars). Moreover, this vague denial prejudiced Petitioners in litigation as they defended against the exclusion claimed at administrative level by Crossmark, GPA and CIGNA (Workers Comp) and did not prepare for so as to adequately defend against other exclusion(s) and/or interpretation(s) later claimed by Administrators. Moreover, they did not develop alternative arguments against those new exclusions: that GPA's exclusion is not subjunctive but workers comp only; that CIGNA's exclusion doesn't apply because of an inherent ambiguity in the plan between work-place exclusions and pre-existing condition allowable claims.

Despite the courts below finding that Petitioners were not harmed by the failure of notice under ERISA or Fed. R. Civ. Proc. Rule 8, this decision, too, was influenced by the abuse of discretion review. Essentially, the courts were constrained to defer to the administrators' relative freedom in interpreting their plans so as to justify claim denial, whether in compliance with civil procedure or not and whether in compliance with ERISA notice or not. The adoption of a *de novo* standard of judicial review is especially necessary in those cases where, as here, the Administrator's procedural violations result in substantive harm to the benefit claimant. It would ensure that such administrator abuses did not go unchecked. It would also ensure that such abuses are not rubber stamped by courts claiming tied hands.

C. The Fifth Circuit's rejection (by affirmation) of the Reasonable Expectation Doctrine presents a conflict between the circuits on this important question of federal common law under ERISA

In *Firestone Tire and Rubber v. Bruch*, this Court held that "courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans'" *Firestone*, 489 U.S. 101, 110, 109 S.Ct. 948, 954 (1989) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56, 107 S.Ct. 1549, 1558 (1987)). One such area of federal common law regulating rights and obligations under ERISA is the "Reasonable Expectations" doctrine.

Under Reasonable Expectations, an Administrator waives reliance on (1) plan language that is ambiguous, as it will be construed against the drafter and in accordance with the reasonable expectations of the insured (*See Gallagher v.*

Reliance Std. Life Ins. Co., 305 F.3d 264, 269 (4th Cir. 2002); (2) plan exclusions that are not clear and conspicuous (*Se Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 38 (9th Cir. 1994)); and (3) plan or claims administration tha interferes with a beneficiary's reasonable expectation o coverage (*See Ruttenberg v. United States Life Ins. Co.* , 41 F.3d 652, 668 (7th Cir. 2005)). As to the third element, a administrator may not accept premium payments whil constructively terminating benefits. *See Tester v. Reliance Standard Life Ins. Co.*, 228 F.3d 372, 377 (4th Cir. 2000).

Although rejected in the case below, the Reasonable Expectations Doctrine has been accepted in numerous circuits, including the Second Circuit (*Lifson v. INA Life Ins. Co. Of New York*, 333 F.3d 349, 353 (2nd Cir. 2003)); Third Circuit (*Heinglein v. Informal Plan for Plant Shutdown Benefits* at 401 (3rd Cir. 1992); *Gallagher* at 269 (4th Cir. 2002)); Fourth Circuit (*Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995)); and Ninth Circuit (*McClure v. Life Ins. Co. Of N. Am.*, 84 F.3d 1129, 1135 (9th Cir. 1996); *Estate of Shockley v. Alyeska Pipeline Service Co.*, 130 F.3d 403 (9th Cir. 1997) (limiting the doctrine to welfare-benefit ERISA plans, and not pension plans under ERISA)).

In addition to the Fifth Circuit's refusal to consider the Reasonable Expectations Doctrine in ERISA in this case, the Tenth Circuit has held the doctrine inapplicable to ERISA. *See Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101 (10th Cir. 1999).

The Seventh Circuit has never expressly decided the question. In *Hightshue v. AIG Life* at 1150 (7th Cir. 1998), the Seventh Circuit noted in dicta that reasonable expectations may not be applicable to ERISA. In a later decision, the Seventh Circuit seemingly approved of the doctrine, but decided the

case on other grounds. *See Ruttenberg v. United States Life Ins. Co.*, 413 F.3d 652, 668 fn. 19 (7th Cir. 2005).

The lead case among the circuits on the contours of the Reasonable Expectations Doctrine is *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994). In *Saltarelli*, the Ninth Circuit found justification for the doctrine in furthering the statutory purposes and disclosure requirements of ERISA. *Id.* at 386-87. That is, that holding ERISA-governed insurance plans to the Reasonable Expectations standard of interpreting the plan documents is consistent with, and furthers, ERISA statements that disclosure of plan terms is to made "in the interests of employees and their beneficiaries." *Saltarelli* at 386-87 (citing 29 U.S.C. § 1001). Moreover, the Ninth Circuit found support for the doctrine in the insurance laws of (at the time) "at least thirty states" and the *contra proferentum* doctrine applied in ERISA cases in the Fifth and Eighth Circuits. *Saltarelli* at 386-87.

Under the Reasonable Expectations doctrine in this case, the inconspicuous, buried and mislabled exclusions in the GPA and CIGNA plans require the Court to order benefit payment in accordance with Petitioners' reasonable expectation of coverage. Moreover, the ambiguity in the GPA plan exclusion as to whether it applies to worker's compensation coverable injuries or all work-related injuries would be construed in accordance with Petitioners' expectations of coverage. Additionally, the ambiguity as to whether Petitioner is covered under allowed pre-existing conditions or excluded under a competing work-related exclusion under the CIGNA policy would be construed in Petitioners' favor. Finally, CIGNA's constructive termination of Petitioners' benefits would not meet Petitioners' reasonable expectation of coverage.

CONCLUSION

The facts of the case below typify the "unjust an tangled" ERISA regime Justice Ginsburg referred to in *Aetn v. Davila*. The Administrators flouted ERISA's disclosur provisions, providing no copies of the ERISA plans or SPDs t employees and beneficiaries. The Administrators changed th plan to specifically exclude Mr. Murray. The Administrator buried plan exclusions within the plan. The Administrator continued to accept premium payments while ordering claim adjusters to deny all claims. The Administrators denied claim on the basis of one exclusion (or interpretation of it) at the Administrative phase and switched to a new exclusion (interpretation) in the middle of litigation.

And to this, the Courts have deferred to the Administrators' discretion. The Courts have found that Petitioners have no recourse to state fair insurance practice law. The Courts found no substantive recourse under ERISA for these gross procedural abuses, except for the woefully inadequate $100 a day fine set in the 1970's for disclosure violations. The Courts found that an unjust, abusive and, by definition, arbitrary ERISA administrator is still free to deny claims under these circumstances at its discretion, outside the constraints of state contract and insurance law.

This Court should grant the Petition for Certiorari in order to resolve the split in the circuits regarding the applicability of the Reasonable Expectations Doctrine to ERISA welfare-plan benefit claims cases. This doctrine needs to become part of the federal common law governing ERISA so as to check unjust and abusive ERISA practices. Court review of administrator's claim practices and plan interpretation according to this doctrine would help fulfill ERISA's purpose of providing benefits to employees.

This Court should grant the Petition for Certiorari in order to reconsider the standard of review in cases involving an ERISA administrator giving itself discretion. Requiring a *de novo* review in all ERISA welfare-benefit plan cases would check unjust and abusive ERISA practices. Certainly, *de novo* review would be an appropriate standard on a showing of an Administrator's procedural violations. *De novo* review of ERISA claims would untangle at least one of ERISA's injustices – the perverse disincentive ERISA administrator's now have to pay valid claims. The correction of this disincentive is necessary to effectuate ERISA's statutory purposes. *See* 29 U.S.C. §§ 1001(a); 1001b(c).

The petition for writ of certiorari should be granted.

Respectfully Submitted,

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United States Court of Appea
Fifth Circuit
FILED
January 23, 2006
Charles R. Fulbruge III
Clerk

UNITED STATES COURT OF APPEALS
For the Fifth Circuit

No. 04-51253

NEVA MURRAY, Individually and as Guardian of Hugh Murray, Ward

Plaintiff-Appellant,

VERSUS

CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE COMPANY; ET AL.,

Defendants-Appellees.

Appeal from the United States District Court
For the Western District of Texas

(5:03-CV-85)

Before HIGGINBOTHAM, DeMOSS, and OWEN Circuit Judges.

PER CURIAM:[****]

Plaintiff-Appellant Neva Murray appeals the distric court's affirmance of the denial of her benefits claim on th basis of an ERISA-plan exclusion. We AFFIRM.

Defendant-Appellee Crossmark Sales, Inc ("Crossmark") employs Murray. Since 1996, Murray ha participated in Crossmark's Medical Plan, a self-funded pla providing medical, prescription drug, and vision benefits t plan participants under the terms of both the Plan Documen and the Summary Plan Description (the "SPD").[5] Upon joinin the Plan, Murray signed an enrollment application, agreeing t be bound by the terms and conditions of the Plan Document an the SPD.

As Plan administrator, Crossmark delegated clain administration to a third party claims administrator, which wa empowered to make benefit determinations. Over the course o Murray's participation in the Plan, at least two claim administrators were named by Crossmark. In 1997, Defendant-Appellee Group & Pension Administrators, Inc. ("GPA") became the claims administrator. Then, on March 29, 2000 Murray enrolled her husband, Mr. Hugh Murray, as a dependent beneficiary in the Plan. Mr. Murray was self-employed as a pest control contractor at that time. On March 1, 2001, Crossmark replaced GPA with Defendant-Appellee Connecticut General Life Insurance Company ("CIGNA") as claims administrator. Thus, effective March 1, 2001, CIGNA exercised its discretion to make benefit determinations under the Plan for claims occurring on or after March 1, 2001.

[****]Pursuant to 5TH CIR. R. 47.5, the Court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

[5]All parties conceded before the district court that the Plan is an employee benefit plan under the Employee Retirement Income and Security Act ("ERISA"), 29 U.S.C. § 1002 *et seq*.

On February 12, 2001, Mr. Murray suffered serious injury when he fell from an attic onto a concrete floor while performing pest control work for profit at his customer's residence. Mr. Murray's medical bills exceed $500,000. Murray submitted claims to GPA for expenses incurred for his treatment through February 28, 2001. During investigation into the claim, Murray averred that her husband's injuries were work related. GPA sent a denial of benefits notice to Murray, indicating that Mr. Murray's injuries were not covered because of an exclusion of coverage for any work-related injury.[6] Crossmark also instituted its own investigation and likewise concluded that Mr. Murray's injuries were expressly excluded under the Plan's terms. When CIGNA replaced GPA as the claims administrator, the Plan was amended, and Crossmark gave its employees notice of the material amendments as

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[6]The SPD, under GPA's administration, provided,

> The following exclusions and limitations apply to expenses incurred by all Covered Persons:
>
> . . .
>
> 3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

The SPD, under CIGNA's administration, provided,

> No payment will be made for expenses incurred for you or any one of your Dependents:
> • for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
> • for or in connection with a Sickness which is covered under any workers' compensation or similar law.

required by ERISA, 29 U.S.C. § 1024(b)(1) ("The administrat shall furnish to each participant, and each beneficiary receivin benefits under the plan, a copy of the summary pla description, and all modifications and changes referred to in [2 U.S.C. § 1022(a)] . . . .").

Because of the change in the entity administratin claims, Murray submitted claims for expenses incurred afte March 1, 2001 to CIGNA. Unlike GPA, CIGNA uses a syster of claims administration called "pay and chase." Consisten with this system, CIGNA initially paid Murray based upon th claims received and then instituted an investigation. CIGN/ paid approximately $90,000 in benefits but, after investigation determined that Mr. Murray's claims were barred by the work related exclusion. Murray contested the denials, and, in its rol as claims administrator at the time, CIGNA affirmed th decision to deny Mr. Murray's claims for benefits.

Murray filed this lawsuit against Crossmark, GPA, an CIGNA (collectively, "Defendants"), arguing that the denial o benefits was arbitrary and capricious, resulting in an abuse o discretion. The Defendants filed a motion for summary judgment, arguing that Murray's claims were barred by the exclusions and limitations included in the SPD. Murray filed a motion for partial summary judgment on February 27, 2004. On July 22, 2004, the district court denied Murray's motion for partial summary judgment, granted judgment for GPA and CIGNA, and granted in part judgment for Crossmark as to the denial of benefits of claim. By stipulation, the parties dismissed with prejudice Murray's remaining claim against Crossmark. Murray timely appealed the district court's grant of judgment on October 4, 2004 to Defendants.

This Court reviews *de novo* the district court's grant of summary judgment, applying the same standards as the district court. *Young v. Equifax Credit Info. Servs., Inc.*, 294 F.3d 631, 635 (5th Cir. 2002); *see also* FED. R. CIV. P. 56(c). When the plan administrator enjoys authority to make a final

determination of eligibility for claim benefits, as here, we review the plan administrator's denial of benefits for an abuse of discretion. *See Duhon v. Texaco, Inc.*, 15 F.3d 1302, 1305 (5th Cir. 1994); *see also Gosselink v. AT&T, Inc.*, 272 F.3d 722, 726 (5th Cir. 2001).

Murray argues that the district court erred in denying her benefits claim on the basis of an affirmative defense – the work-related exclusion – that Defendants failed to plead. The district court assumed for purposes of analysis, without deciding, that an ERISA-plan exclusion must be pled as an affirmative defense under Federal Rule of Civil Procedure 8(c). The district court then determined that Defendants did not waive the defense provided by the work-related exclusion in failing to plead it. Rule 8(c)'s provision that waiver results from a failure to plead is not absolute because "[w]here the matter is raised in the trial court in a manner that does not result in unfair surprise, . . . technical failure to comply precisely with Rule 8(c) is not fatal." *Allied Chem. Corp. v. Mackay*, 695 F.2d 854, 855-56 (5th Cir. 1983); *Jones v. Miles*, 656 F.2d 103, 107 n.7 (5th Cir. 1981); *see also Bull's Corner Rest., Inc. v. Dir., Fed. Emergency Mgmt. Agency*, 759 F.2d 500, 502 (5th Cir. 1985), *superceded in part by rule on other grounds*, FED. R. CIV. P. 52(a).

We find the work-related exclusions here unambiguous, and the record reflects that Murray was on notice of the work-related exclusion in the SPDs prior to the filing of the lawsuit. Murray concedes that the Defendants asserted the work-related exclusion in their June 11, 2003 Motion to Limit Discovery, filed over eleven months before the trial setting. Furthermore, Defendants affirmatively pled in their answer to Murray's Second Amended Complaint that the claims were denied "in accordance with the terms and conditions of the Plan." Based on this record, the district court did not err in concluding that the work-related exclusion defense was not waived, nor did the court err in concluding that the denial of benefits under the

unambiguous terms of the work-related exclusions was neithe arbitrary nor capricious.

After thorough review of the briefs, the oral argument of the parties, and relevant portions of the record, we AFFIRM the district court's judgment for Defendants on Murray's denia of benefits claim essentially for the well-stated reason provided by the district court.

AFFIRMED.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

NEVA MURRAY, INDIVIDUALLY, AND AS GUARDIAN OF HUGH MURRAY, WARD Plaintiffs,	§	
v.	§	NO. SA.03 -CA-0085-XR
CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE COMPANY A/K/A CIGNA HEALTHCARE; and GROUP&PENSION ADMINISTRATORS, INC. Defendants.	§	

FINAL JUDGMENT

On July 22, 2004, the Court granted the Motions for Summary Judgment filed by the Defendants, CROSSMARK, Inc. (improperly named "CROSSMARK Sales, Inc."), Group & Pension Administrators, Inc., and Connecticut General Life Insurance Company a/k/a CIGNA HealthCare and dismissed with prejudice Plaintiffs', Neva Murray, Individually, and as Guardian of Hugh Murray, Ward, claims for a declaratory judgment and wrongful denial of benefits under 29 U.S.C. § 1132(a)(1)(B) contained in the Plaintiffs' Second Amended Complaint. In the summary judgment Order, the Court allowed Plaintiffs to amend their complaint to assert a claim for statutory penalties under 29 U.S.C. § 1132(c) against

CROSSMARK, Inc. On or about July 30, 2004, Plaintiffs file a Third Amended Complaint that asserted five addition: Counts against CROSSMARK, Inc. and filed a Motion fc Leave to File Count Five in that Third Amended Complaint. O August 30, 2004, the Court issued an Order that denie Plaintiffs' Motion for Leave to add Count Five and dismisse Counts One and Two, leaving only Counts Three and Four i the Third Amended Complaint. The parties have informed th Court that they have resolved Plaintiffs' claims for penaltie under 29 U.S.C. § 1132(c) in the Third Amended Complain and have presented the Court with their Agreed Dismissa Order.

It appearing to the Court that all claims in this matte have been disposed of, it is therefore ORDERED ADJUDGED, and DECREED, that Plaintiffs, Neva Murray Individually and as Guardian of Hugh Murray, Ward, take nothing on any of their claims against Defendants asserted ir this lawsuit. Costs to be borne by the party incurring same.
DATED: October 4, 2004

XAVIER RODRIGUEZ
United States District Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

NEVA MURRAY, et al.	)	
Plaintiffs,	)	
VS.	)	Civil Action No:
	)	SA-03-CA-85-XR
CROSSMARK SALES,	)	
INC., et al.	)	
Defendants.	)	

.ORDER

On this date, the Court considered Defendants Crossmark, Inc. ("Crossmark") and Group & Pension Administrators, Inc.'s ("GPA") joint motion for summary judgment (docket no. 52), which was joined by Defendant Connecticut General Life Insurance Company ("CGLIC") and the responses. The Court also considered Plaintiffs' motion for partial summary judgment (docket no. 54) and the responses. Because the Plan Administrator's decision to deny benefits under the work-injury exclusion was not arbitrary and capricious, Plaintiffs are not entitled to recover benefits under the plan. However, because a fact issue exists as to whether Crossmark adequately provided a Summary Plan Description to Plaintiffs, Plaintiffs may amend their complaint to assert a claim for statutory administrative penalties. Thus, Defendants' Motion for Summary Judgment is GRANTED in part, and DENIED in part (docket no 52). Plaintiffs' Motion is DENIED (docket no. 54).

I.

Facts and Procedural Background

Hugh Murray was self-employed as a pest contr exterminator, and during the course of his employment, fe from an attic on February 12, 2001. The fall left him comatos for five weeks and hospitalized for an extended perio Subsequently, he was moved to a nursing facility. His wife an guardian, Neva, brought this suit seeking a declaration o whether the medical plan offered by her employer, Crossmark and administered by GPA and later CGLIC,[1] is an "employe benefit plan" under the Employee Retirement Income an Security Act ("ERISA"), 29 U.S.C. §§ 1002, *et seq.* All parties however, now concede that the plan is an ERISA plan. Thus her remaining claim argues that Defendants' decision to den benefits was arbitrary and capricious resulting in an abuse o discretion. She seeks to recover benefits under the plan, an attorney's fees incurred in bringing this suit.

II.

Summary Judgment Standard

A summary judgment movant must show by affidavit o other evidence that there is no genuine issue regarding an material fact. *Celotex Corp. v. Catrett, 477* U.S. 317, 32 (1986). To establish that there is no genuine issue as to an material fact, the movant must either submit evidence tha negates the existence of some material element of the nonmoving party's claim or defense, or, if the crucial issue is one for which the nonmoving party will bear the burden o

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[1]On March 1, 2001, CGLIC (also known as CIGNA) replaced GPA as the claims administrator.

proof at trial, merely point out that the evidence in the record is insufficient to support an essential element of the nonmovant's claim or defense. *Lavespere v. Niagra Machine & Tool Works, Inc.*, 910 F.2d 167, 178 (5th Cir. 1990), *cert. denied*, 510 U.S. 859 (1993). Once the movant carries its initial burden, the burden shifts to the nonmovant to show that summary judgment is inappropriate. *See Fields v. City of South Houston*, 922 F.2d 1183, 1187 (5th Cir. 1991).

Summary judgment is required if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. F ED. R. CIV. P. 56(c); *Celotex Corp.*, 477 U.S. at 322. In order for a court to conclude that there are no genuine issues of material fact, the court must be satisfied that no reasonable trier of fact could have found for the nonmovant, or, in other words, that the evidence favoring the nonmovant is insufficient to enable a reasonable jury to return a verdict for the nonmovant *See Anderson v Liberty Lobby, Inc*, 477 U.S. 242, 250 n.4 (1986). In making this determination, the court should review all the evidence in the record, giving credence to the evidence favoring the nonmovant as well as the "evidence supporting the moving party that is uncontradicted and unimpeached, at least to the extent that evidence comes from disinterested witnesses" and disregarding the evidence favorable to the nonmovant that the jury is not required to believe. *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 152 (2000).

III.

Analysis

A. ERISA Generally

ERISA authorizes federal court review of a pla administrator's denial of a claimant's claim. 29 U.S.C. 1132(a)(1)(B). Factual determinations made by an administrat under an ERISA plan are reviewed for an abuse of discretio *Pierre v. Conn. Gen. Life Ins. Co.,* 932 F.2d 1552,1562 (5t Cir.), *cert. denied,* 502 U.S. 973 (1991). So long as the ERIS benefit plan provides the plan administrator with discretionar authority to construe the terms of the plan, the pla administrator's denial of benefits is also reviewed for an abus of discretion. *Gosselink v. AT&T, Inc.,* 272 F.3d 722,726 (5' Cir. 2001). When a court applies the abuse of discretio standard, it analyzes whether the plan administrator acte arbitrarily or capriciously. *Lain v. UNUM Life Ins. Co. of Am.* 279 F.3d 337, 342 (5th Cir. 2002). Thus, "[a]n administrator' decision to deny benefits must be 'based on evidence, even i disputable, that clearly supports the basis for its denial. " *Id citing Vega v. Nat'l Life lns. Servs. Inc.,* 188F.3d 287, 299 (5' Cir. 1999).

B. The Crossmark Plan

The plan administrator denied Plaintiffs' claim fo medical benefits based on an exclusion for on the job injuries. The Crossmark Major Medical Plan, effective January 1 , 1997, and restated January 1, 1999, contained the following exclusion under Major Medical Plan Exclusions and

Limitations:

3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease

Law, or any such similar law.

With the change of administrators in March of 2001, the Plan was modified and the language was changed to read:

> No payment will be made for expenses incurred for you or any one of your Dependents for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.

Plaintiffs do not contest that Mr. Murray was injured during the course and scope of his selfemployed extermination business. Further, other than the issues raised below, Plaintiffs do not dispute that the plan administrator had discretionary authority to construe the plan or that the administrator's decision was not arbitrary or capricious.

C. Plaintiff argues the work-related exclusion is an affirmative defense that was not pled and has been waived.

Plaintiffs argue that Defendants have not pled the above exclusion as an affirmative defense, and as such, the affirmative defense has been waived. Assuming without deciding that exclusions in an ERISA plan are affirmative defenses subject to Federal Rule of Civil Procedure 8(c), Defendants' failure to plead the exclusion did not result in waiver because Plaintiffs cannot argue they were prejudiced. Although it is well established that a failure to plead an affirmative defense "generally results in a waiver," the rule is not without exception. *Allied Chem. Corp. v. Mackay*, 695 F.2d 854, 855-56

(5th Cir. 1983). When a "matter is raised . . . in a manner tha does not result in unfair surprise, . . . technical failure to compl precisely with [Rule 8(c)] is not fatal." *Id.* Plaintiffs have bee aware that Defendants relied upon the work-related exclusio since 2001, years prior to this lawsuit ever being filed. Furthe the work-related exclusion was referenced throughout th discovery process and the dispositive motions. *See Allian Versicherungs, AG v. Profreight Brokers Inc.,* 99 Fed. Appx 10, 12 (5th Cir. 2004). Given that the Plaintiffs have not bee surprised or prejudiced by Defendants' failure to state th exclusion specifically in its answer, the defense has not bee waived.

D. Plaintiffs urge the Court to adopt the doctrine o reasonable expectations.

Alternatively, Plaintiffs argue that the doctrine o reasonable expectations requires that an exclusion be conspicuous, plain and clear in order to be enforceable. "Unde the 'reasonable expectations' doctrine, as a matter of federal common law governing ERISA contracts, even an unambiguous exclusion maybe unenforceable unless it is sufficiently 'clear, plain, and conspicuous' to overcome a layperson's reasonable expectations." *Saltareii v. Bob Baker Group Med. Trust,* 35 F.3d 382, 385-87 (9th Cir. 1 994). Neva Murray states that she was given Crossmark's "Benefits with Choice, Enrollment Guide and Benefits Summary" to review in order to decide whether she would enroll herself and her family in the medical plan. She argues that she was not given a copy of the SPD, and that in the materials given to her at the time of her enrollment, there was no reference to a work-related injury exclusion. Additionally, Plaintiffs argue that because GPA initially made medical benefit payments on behalf of Mr. Murray that they had a reasonable expectation of benefits under the policy.

However, because the Fifth Circuit has not specifically adopted the doctrine of reasonable expectations in the ERISA context, and *Saltarelli* relied in part upon California state law for its holding, this Court refuses to adopt this doctrine.

Defendants argue that even if the Court did accept the doctrine of reasonable expectation, Plaintiffs were made aware of the exceptions and technical support was made available to them if they had any questions. Defendants state that Neva Murray was continually enrolled in Crossmark's Medical Plan since 1996, and that the Plan created a work-related exclusion in 1997. At the time of her enrollment, Defendants argue that the Summary Plan Description ("SPD") "was available to all participants through Crossmark's Human Resources Department." They further argue that in 1999, Crossmark posted the SPD on public folders in its computer system, which could be accessed by all employees. Accordingly, Defendants argue that when Neva Murray enrolled her husband in the Medical Plan on March 29, 2000, a SPD existed that contained the work-related exclusion, a copy of the SPD was made available to her through the public folders of Crossmark's computer system, and she was aware that GPA was the Plan Administrator and could have called them or Crossmark's human resources department with any questions regarding coverage.

As stated above, Crossmark's ERISA Plan became effective in 1997, and the Plan was restated on January 1, 1999. The Plan Document and SPD was 71 pages in length. *See* Exhibit A-S of Defendants' Motion for Summary Judgment and Brief in Support (docket no. 52). The Table of Contents contained a category titled Major Medical Plan Exclusions and Limitations (pages 27-29). The work-related exclusion is found on page 27 and is listed as exclusion number 3 of 53. On April 11, 2000, after Neva Murray enrolled her husband in the medical plan but before his injury, Crossmark employees were

notified that GPA had a web site to assist with customer servic issues. On January 1 5, 2001, Crossmark notified its employe that a new benefits plan was being instituted effective March 2001. Employees were provided an enrollment guide an directed to contact the Benefits Department with any questior they may have. Thus, even if the Court adopted the doctrine c reasonable expectations, the exclusion was plain, clear, an sufficiently conspicuous. In this case the SPD is unambiguou regarding the work-related exclusion. Although any failure b Defendants to adequately provide Plaintiffs with a SPD ma trigger liability under ERISA's notice and provision sectior *(see infra* relating to 29 U.S.C. § 1132(c)(1)), any such failur does not affect their substantive rights under the Plan, or th decision of the plan administrator.[2]

This case is similar to *Scott v. Poly-Tech, Inc.,* 1999 W. 33120743 (N.D. Miss. 1999), *aff'd,* 234 F. 3d 706 (5th Ci 2000). In *Scott,* the plaintiff was denied benefits based on a pre existing medical condition provision. Scott argued that the Pla Administrator could not deny her coverage based on th exclusion because she was not provided with a copy of th SPD. The plaintiff further argued that agents of the Pla Administrator made oral representations to her that she woul be entitled to full medical coverage. Scott could not argue tha the Plan Administrator's decision was arbitrary or capricious accordingly she argued that the Plan should be estopped fror denying coverage because of the failure to provide a SPD. I

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[2]Plaintiffs cannot offer evidence that the plan administrator's decision was the product of an arbitrary decision or the plan administrator's whim. Plaintiffs are unable to overcome the fact that Mr. Murray was injured during the course of his employment, and the Plan clearly excluded such an injury from coverage. *See Tillery v. Hoffman Enclosures, Inc.,* 280 F.3d 1192, 1198 (8th Cir. 2002) ("The Tillerys also question whether they ever received a copy of the SPD. Assuming they did not, they fail to explain how such an oversight affected their substantive rights or the decision of the plan administrator.").

reviewing the statute and cases the Court in *Scott* concluded that there was "nothing within the statutory provision suggesting that a plan beneficiary should receive a benefit award based on a plan administrator's failure to disclose required information." The *Scott* court reached its decision because "ERISA's remedial structure presents a detailed reasoned compromise between plan participants' need for adequate disclosure and the disincentives expansive liability for nondisclosure might present to employers considering institution" of ERISA plans.

In this case, neither under a "reasonable expectation" or estoppel theory may Plaintiffs avoid the binding effect of the Plan's exclusion.

Further, with regard to GPA's initial payment of medical benefits, Plaintiffs' reliance upon *Pitts By and Through Pttls v. American Sec. Life Ins. Co.,* 931 F.2d 35 1 (5th Cir. 1991) is misplaced. In *Pitts,* the Fifth Circuit found that the insurer had waived a condition of the policy upon which it attempted to rely in denying coverage. The group policy at issue in that case required a minimum number often employees to enroll before coverage would be effective. However, the insurer in that case accepted premiums from the employer on the group policy for five months after knowing for all five months, "beyond all doubt," that the insured was the only person remaining on the policy. Thus, it was absolutely clear that the number of enrollees to the policy fell well below the number required for quite some time. In this case there is no knowing and intentional waiver on the part of Defendants to waive the work-related exclusion. GPA merely timely paid medical benefits while it simultaneously investigated the circumstances upon which Mr. Murray became injured.

E. Alternatively, Plaintiffs argue Defendants failed t provide a summary plan description.

Alternatively, Plaintiffs seek administrative penaltie against Defendants for failure to timely provide a SPD. 2 U.S.C. § 1132(c)(l). Although Plaintiffs state that none of th Defendants have ever furnished Plaintiffs with a SPD [3], th Court understands their argument to be that the 1999 SPI notice was ineffective because it was done in an electroni format, and the SPD was not easily retrievable withi Crossmark's computer system. Defendants complain tha Plaintiffs have never pled a claim under 1132(c)(1) Alternatively, GPA and CGLLC/CIGNA argue tha administrative penalties under that section may only b assessed against the Plan Administrator Crossmark, not third party claim administrators.

ERISA's administrative penalty provision provides fo the assessment of civil penalties against the plan administrato The relevant text of29 U.S.C. § I 132(c)(1)(B) provides that:

> Any administrator . . . who fails or refuses to compl with a request for any information which sucl administrator is required by this subchapter to furnish t a participant or beneficiary (unless such failure o refusal results from matters reasonably beyond th control of the administrator) by mailing the materia requested to the last known address of the requestin participant or beneficiary within 30 days after sucl request may in the court's discretion be personally liabl to such participant or beneficiary in the amount of up t

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[3] It is uncertain from the summary judgment evidence whether Plaintiffs, prior to or after Mr. Murray's injury, ever requested a copy of the SPD.

> $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

The term "administrator" refers to the person specifically designated by the terms of the instrument, or, if an administrator is not so designated, the plan sponsor. 29 U.S.C. § 1002(16)(A)(i) and (ii).

Crossmark is designated in the SPD as the administrator. Accordingly, Plaintiffs are unable to assert claims against either GPA or COLIC/CIGNA. Accordingly, summary judgment in favor of GPA and CGLIC/CIGNA is proper as to any 29 U.S.C. § 1132(c) claim. *See also Newell ex rel. Snow v. Aetna Life Ins. Co.,* 2002 WL 1840925, at *3 (N. D. Tex. Aug 08, 2002).

With regard to Crossmark, Plaintiffs presume that a "hard copy" of the SPD must be handed to an employee or plan participant. The federal regulations implementing ERISA's disclosure requirements, however, provide for electronic notification. *See* 29 C.F.R. 2520. 104b- 1(c)(1)(i), (iii), and (iv). However, the regulations also provide that electronic notification is satisfactory only if "the administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents results in actual receipt of transmitted information." *Id.* Neither party has adequately addressed the issue of whether electronic communication of the SPD met this standard. While Crossmark argues that a claim for administrative penalties has not been pled, it appears that the issue of whether the SPD was properly transmitted to Plaintiffs has been an issue since the date Mr. Murray was injured. Given that Defendant Crossmark has not been surprised or prejudiced by the Plaintiffs' failure to specifically plead a 1132(c)(1) claim in the Complaint, the

Court will allow Plaintiffs to amend their Complaint to asse such a claim against Crossmark.

In the alternative, Crossmark, relying upon *Hatteberg v Red Adair Co., Inc. Employees' Profit Sharing Plan and it Related Trust,* 79 Fed. Appx. 709, 715 (5th Cir. 2003),[4] argue that even if Plaintiff could assert a 1132(c) claim, such a clain would be barred by the four year limitations period. Crossmar asserts that the four-year period began in 1996, when Plaintif first enrolled in her employer's medical plan. The Court however, finds that fact issues exist regarding when th limitations period began. The summary judgment evidenc tendered to the Court indicates that Crossmark did not begin it electronic posting of the SPD until 1999. There is no evidenc before the Court that SPDs were provided to employees prio to that date. Because Plaintiff filed her suit in 2003, her caus of action for statutory penalties may be well within the fou year limitation period.

Conclusion

The Court concludes that, for the reasons stated above Defendants' motions for summary judgment is GRANTED, ir part (docket no. 52). The Court concludes that the medical plar offered by Crossmark, and administered by GPA and late CGLIC/CIGNA is an "employee benefit plan" under ERISA. Under this plan, the Plan Administrator's decision to deny benefits under the work-injury exclusion was not arbitrary and capricious. Plaintiffs are therefore not entitled to recove benefits under the plan.

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[4]Under the Fifth Circuit's Rule *47.5.4,* decisions not selected for publication carry no precedential weight, but may be used as persuasive authority.

The Court further concludes that Plaintiffs' motion for partial summary judgment is DENIED (docket no. 54). The Court, without deciding that exclusions in an ERISA plan are affirmative defenses subject to Federal Rule of Civil Procedure 8(c), finds that Defendants' failure to plead them did not result in waiver because Plaintiffs were not surprised or prejudiced. Thus, Defendants are not barred from asserting their exclusionary defense. In addition, the Court refuses to adopt the doctrine of reasonable expectations in the ERISA context. However, because a fact issue exists as to whether Crossmark adequately provided a SPD to Plaintiffs, Plaintiffs may amend their Complaint to assert this cause of action.

It is ORDERED that Plaintiffs must amend their pleading within 10 days to add their section 1132(c) claim.

Plaintiffs and Crossmark are ORDERED to submit this case to mediation within the next 30 days. The Court has attached a list of mediators. If the parties cannot agree to a mediator within the next 15 days, Plaintiffs are to notify the Court of this fact, and the Court will thereafter appoint a mediator.

The Court concludes that a fact issue exists as to whether Plaintiffs, prior to or after Mr. Murray's injury, ever requested a copy of the SPD, whether Crossmark satisfactorily provided Plaintiffs a copy of the SPD, and whether the 1132(c) claim is barred by limitations. Thus, if mediation is not successful, it is FURTHER ORDERED that Plaintiffs and Crossmark submit additional briefing within 20 days regarding the 1132(c) claim.

It is FURTHER **ORDERED** that all claims again GPA and CGLIC/CIGNA are dismissed.

SIGNED this 22
day of July, 2004

XAVIER RODRIGUEZ
UNITED STATES DISTRICT JUDGE

29 U.S.C. 1001(b)

"(b) Additional findings

The Congress further finds that modification of the current termination insurance system and an increase in the insurance premium for single-employer defined benefit pension plans (1) is desirable to increase the likelihood that full benefits will be paid to participants and beneficiaries of such plans;

* * *

(c) Declaration of policy

It is hereby declared to be the policy of this title * * * (3) to increase the likelihood that participants and beneficiaries under single-employer defined benefit pension plans will receive their full benefits. . . ."

29 U.S.C. 1022. Summary Plan Description

"(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries. . . . The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

(b) The summary plan description shall contain the following information: * * * the plan's requirements respecting eligibility for participation and benefits. . . ."

29 U.S.C. 1024 (b) Publication of summary plan description and annual report to participants and beneficiaries of plan.

"Publication of the summary plan descriptions and annua reports shall be made to participants and beneficiaries of th particular plan as follows:

(1) The administrator shall furnish to each participant, and eac beneficiary receiving benefits under the plan, a copy of th summary plan description, and all modifications and change * * * (B)If there is a modification or change described i section 1022 (a) of this title that is a material reduction i covered services or benefits provided under a group health pla . . . a summary description of such modification or change sha be furnished to participants and beneficiaries not later than 6 days after the date of the adoption of the modification c change."

29 U.S.C. 1133. Claims Procedure.

"In accordance with regulations of the Secretary, ever employee benefit plan shall (1) provide adequate notice i writing to any participant or beneficiary whose claim fc benefits under the plan has been denied, setting forth th specific reasons for such denial, written in a manner calculate to be understood by the participant, and (2) afford a reasonabl opportunity to any participant whose claim for benefits ha been denied for a full and fair review by the appropriate name fiduciary of the decision denying the claim."

29 C.F.R. 2520.104b-. Disclosure.

"(a) *General disclosure requirements.* The administrator of an employee benefit plan covered by Title I of the Act must disclose certain material, including reports, statements, notices, and other documents, to participants, beneficiaries and other specified individuals.

* * *

(c) *Disclosure through electronic media.*

(1) ... the administrator of an employee benefit plan furnishing documents through electronic media is deemed to satisfy the requirements of paragraph (b)(1) of this section with respect to an individual described in paragraph (c)(2) if:

(i) The administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents (A) Results in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information) * * * (iii) Notice is provided to each participant, beneficiary or other individual ... of the right to request and obtain a paper version of such document; and (iv) Upon request, the participant, beneficiary or other individual is furnished a paper version of the electronically furnished documents.

(2) Paragraph (c)(1) shall only apply with respect to * * * (ii) A participant, beneficiary or any other person entitled to documents . . . who (A) . . . has affirmatively consented * * * (C) Prior to consenting, is provided . . . a clear and conspicuous statement indicating: (4) The right to request and obtain a paper version. . . ."

29 C.F.R. 2520.104b-3. Material Modifications

"(d) *Special rule for group health plans*—(1) *General.* ...Th administrator of a group health plan ... shall furnish to eac participant covered under the plan a summary, written in manner calculated to be understood by the average pla participant, of any modification to the plan or change in th information required to be included in the summary pla description, within the meaning of paragraph (a) of this sectio that is a material reduction in covered services or benefits n later than 60 days after the date of adoption of the modificatio or change."

29 C.F.R. 2520.107-1. Use of Electronic Media.

"(b) *General requirements.* The record maintenance and retention requirements of sections 107 and 209 of ERISA ar satisfied when using electronic media if * * * (3) The electronic records are readily convertible into legible and readable paper copy as may be needed to satisfy reporting and disclosure requirements or any other obligation under Title I of ERISA."

29 C.F.R. 2560.503-1. Claims Procedure.

"(a) *Scope and purpose.* ...[T]his section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants).

* * *

(b) *Obligation to establish and maintain reasonable claims procedures.* Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if

* * * (2) A description of all claims procedures ... and the applicable time frames is included as part of a summary plan description . . .; (3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits * * * (5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents

* * *

(g) *Manner and content of notification of benefit determination* (1) . . . [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. . . . The notification shall set forth, in a manner calculated to be understood by the claimant (i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based;

* * *

(h) *appeal of adverse benefit determinations* * * * (3) *Grou health plans.* The claims procedures of a group health plan wil not be deemed to provide a claimant with a reasonabl opportunity for a full and fair review of a claim and advers benefit determination unless . . . the claims procedures * * (ii) Provide for a review that does not afford deference to th initial adverse benefit determination and that is conducted by a appropriate named fiduciary of the plan who is neither th individual who made the adverse benefit determination that i the subject of the appeal, nor the subordinate of suc individual."

ACKNOWLEDGMENT OF SERVICE

I, EDWARD L. PINA, certify that today, April _____, 2006, a copy of the Petition for a Writ of Certiorari was served in accordance with Supreme Court Rule 29(3) on all parties required to be served by their counsel of record as indicated below:

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